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## **Social roles and alienation: Breastfeeding promotion and early motherhood**

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## **Social Roles and Alienation: breastfeeding promotion and early motherhood**

### **Abstract**

This paper considers whether the social institutions through which early motherhood is experienced can support non-alienating role identification. Drawing on critical theory's conceptualization of social roles (Jaeggi, Joas), the analysis focuses on 20 interviews with middle-class mothers in Northern Ireland, taken from a larger dual-site study of early motherhood in 2009-10. This region has one of the lowest rates of breastfeeding in the world and has a particularly intensive promotion strategy. Considering respondent experiences of the pressure to breastfeed, the paper examines the consequences of a key institutional definition of good motherhood in the early stages. The paper argues that the effort to rigidly impose a moral code as the role is taken on has potentially alienating effects, as it limits the scope for the agent to appropriate and identify with it. An approach to health promotion which instead trusts women to exercise situated moral judgement about infant care, rather than subjecting them to an externally imposed moral code, would reduce the emotional strain and potential for alienation in early motherhood.

### **Keywords**

Social roles, critical theory, alienation, breastfeeding promotion, motherhood

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## Introduction

Motherhood has undergone significant transformation in recent decades, as the expectation of individual autonomy has reshaped gender and family life (Honneth, 2014: 15). Women now expect to become mothers not because of biological destiny, coercion, or social duty, but instead as an aspect of a self-directed life. Motherhood is expected to be taken on only when it is understood as integral to the agent's realization of her intentions and values (Honneth, 2014: 126; Smyth, 2012).

At the same time, the practices of mothering, particularly in the early stages, have become the focus of intense public interest. Cultural ambiguity about the value of full-time mothering has shifted public debates away from the question of whether mothers should engage in paid employment at all, to a focus on the quality of maternal caregiving. This is driven in Europe by a move towards ideals of shared, non-gendered caring and breadwinning (Ciccia and Bleijenbergh, 2014). In the US, where the norm of the male breadwinner/female homemaker remains strong (Williams et al., 2013), stay-at-home mothers nevertheless feel they lack cultural support and are regarded with suspicion, particularly if they rely on welfare support (Johnston and Swanson, 2004). Some justify their full-time mothering as a 'career choice', presenting themselves as CEOs of their 'corporation' families (Dillaway and Paré, 2008: 449). Time intensive mothering practices, especially breastfeeding, have become an important focus of status claims for both stay-at-home and employed mothers (Currid-Halkett, 2017). Indeed, controversies over infant feeding address a broad range of anxieties, including over the human cost of industrial food production, global inequalities, environmental degradation and the duty to protect children from harm (e.g. see WABA, 2017). It should be no surprise

that the promotion of breastfeeding has become a major focus of public health initiatives across the globe (World Health Organisation and UNICEF, 2015).

How does the promotion of breastfeeding as the hallmark of quality mothering in the early stages (Kukla, 2006) shape women's ability to identify as good mothers, able to perform this role with some authority? What follows will explore this question by examining women's experiences of infant feeding in early motherhood through critical theory's conceptualization of social roles, autonomy and the problem of alienation. The question of whether the social institutions through which early motherhood is experienced can support non-alienating role identification underlies this discussion.

### **Critical Theory on Social Roles and Alienation**

The concept of a social role fell out of favour for sociologists, as it came to be associated with functionalism and behaviourism (Joas and Knöbl, 2009: 134-139). Efforts to conceive of social relations instead as interactional and dynamic turned to concepts such as 'position' and 'performance' as ways of taking account of the interpretive power of agents and the significance of context and inequality in social action (Crossley, 2011: 162). However, the abandonment of the concept of social roles has obscured both the mutual expectations agents have of each other and the claims we make of each other, as constituent features of social life (Joas, 1993: 221).

One alternative to role theory, expectation states theory, originating in social psychology and comparable to labelling theory (Becker, 1963), conceives of social life as normative and

relational, with status stratification reflecting widely shared beliefs about characteristics such as gender, race-ethnicity or age. The moral and behavioural expectations attached to such characteristics, when they become relevant in specific contexts, generates and perpetuates status inequalities (Berger et al., 1972; Berger et al., 1980).

Developing this perspective with respect to gender, Ridgeway argues that we are 'framed before we know it'. The relevance of 'frames', or normative expectations, are not static, but instead are influenced by the social institutions through which action plays out. When a characteristic such as gender is framed as relevant to a situation, distinct normative expectations for women and men are galvanised, informing action and consequently status (2009: 148-149). For example, motherhood carries normative expectations concerning the gendered, low-status characteristic of nurturing. Motherhood also carries high expectations of nurturing competence and low expectations of competence for non-nurturing activities. These expectations become self-fulfilling as mothers develop a general sense of their low competence beyond the maternal role (Ridgeway and Correll, 2004: 685-690).

Expectation states theory's primary focus on characteristics rather than roles results in a static account of social life, as unpredictable role performance is overlooked. A more fully interactive approach would pay attention instead to agents, as they interpret relatively unscripted roles through a complex array of normative expectations (Turner, 1962). The significance of norms in supporting status inequality, not only through their attachment to social characteristics, but also as criteria for evaluating the quality of our role performances, becomes apparent.

Critical theory's approach to social roles takes this more complex, agent-focused approach, assuming that action is not a pre-scripted performance, or a self-interested effort to maintain or improve status position (Joas and Beckert, 2001). Instead action is understood to be roughly guided by social roles, as we interpret them in our efforts to secure various forms of social recognition (Honneth, 1995).

Critical theory conceives of roles as provisional guides to action rather than formal sets of responsibilities, as in military and bureaucratic contexts (Turner, 1962: 22). Consequently, the enactment of roles necessarily entails a twofold interpretive process (Jaeggi, 2014: 87). First, 'role taking' involves comprehending the actions of others as guided by a specific role (Turner, 1956: 316). This tends to inform the associated process of 'role making', namely the realization of a role not by reciting a prescribed script, but by interpreting and modifying it (Turner, 1962: 22).

Through this twofold process our self-conception emerges, Jaeggi argues, as we identify with and develop some command over our roles in situated interactions. Rather than conceiving of the self as pre-social, Jaeggi argues that it is entirely caught up with our roles. We develop a relationship to ourselves and our world through our interactions, as they are mediated by our institutionally anchored roles (2014: 77). A non-essentialist concept of appropriation underpins this account of the social self:

The concept of appropriation refers to a comprehensive conception of practical relations to self and world. It includes a broadly understood capacity of knowing and

dealing with oneself: having access to or command over oneself and the world.

(Jaeggi, 2014: 37)

The self is understood here as the product of role appropriation and identification, an ongoing process which relates one's various roles to each other, even if in ambivalent ways, as they shift and change (Jaeggi, 2014: 122): 'the concept of appropriation emphasises the productive and active character of an unalienated relation to self and world.' (Jaeggi, 2014: 153).

What is at stake for the role-enacting, relational self is not a risk of inauthenticity or disintegration when self and social roles conflict, as Marxist-inspired critics argue (e.g. Hochschild, 2003). Indeed, the Marxist way of conceiving alienation has been central to the critical theory tradition, going back to Hegel (e.g. Rasmussen, 1996: 19). For Marx, who popularised the concept (Nisbet, 1966: 264), alienation was understood to be an effect of exploitative economic relations. From this perspective, the essential human need to express ourselves through creative work was undermined as capitalism harnessed human productivity for profit. As a result, we become alienated from our humanity as we cease to see ourselves in the products of our work, an effect which can only be alleviated by abolishing capitalism (Nisbet, 1966: 290-291).

Jaeggi's recent revision conceptualizes alienation much more broadly as a potential feature of any social institution, not only economic relations. When a social role is closed to interpretation, the possibility of identifying with it and developing a sense of command over it is compromised, with significant consequences for one's self-conception. The experience of

not being present in one's actions results in '... less a distortion of, or a coming away from, the true self than an inner void' (Jaeggi, 2014: 95).

For Marx, alienation under capitalism is reversible, if economic conditions change (Nisbet, 1966: 291). For Jaeggi, by contrast, the self has no essential purpose but is entirely caught up in a multitude of available social roles. A profound sense of emptiness arises when purposeful interpretation and appropriation of social roles is frustrated. Roles which become rigidly defined at the institutional level present the self with an experience of alienation akin to depression (Ehrenberg, 2010). A non-alienated life consequently depends not on the abolition of capitalism, but on roles which are available for appropriation (Jaeggi, 2014: 217).

The possibility of alienation from roles and self reflects the prevalence of autonomy as a major contemporary norm (Honneth, 2014: 17). The power of this norm is evident in the expectation that women take on motherhood intentionally, rather than as a gender-derived duty.<sup>1</sup> Autonomy here is not understood as an individual's entitlement to be left alone to do whatever they want, free from any 'external' constraint, such as the responsibilities of childcare. Neither is it understood as a matter of individual reflexivity, where intentions emerge through inner reflection. Instead, autonomy is understood as what Honneth terms 'social freedom', that capacity to develop intentions through situated social interactions, treated not as an addendum but instead as 'the medium and condition' of a self-directed life. On this account 'individual subjects can perform the reflexive acts required for self-determination only if they interact socially with others who do the same' (Honneth, 2014: 42). Understood in this way, autonomy is neither simple selfishness, nor the opposite of community engagement, but involves the ability to develop intentions through



intersubjective interactions within and across institutions, and to exercise self-control in seeking to realize those intentions. Protecting one's children from an abusive partner, or raising children in a community context, can both be understood as examples of social freedom.

The distinctly moral character of motherhood can be accepted by the agent only if the role can give form to their autonomously developed intentions (Green, 2015). It is crucial, therefore, that the agent can interpret motherhood in relation to those intentions. Without this 'practical command', an agent can experience alienation, as her sense of autonomous selfhood collapses. She is unable to make motherhood her own (Jaeggi, 2014: 38).

### **Breastfeeding Promotion and Role Alienation**

Breastfeeding tends to be experienced as emotionally intense, in positive and negative ways. Sustained breastfeeding is generally understood to depend on self-control, in the form of maternal self-sacrifice and concentrated effort, if it is to be 'successful' (Nelson, 2006: e15). Most women are fully aware of the message that 'breast is best', but tend to act in ways which take account of various other considerations (Carter, 1995). Social research on breastfeeding emphasises the centrality of human relations, interactions, and cultural norms (e.g. Dykes and Flacking, 2010; Leeming et al., 2012). It is telling that those who can establish and sustain breastfeeding report that it 'made them feel like a better mother and/or person' (Nelson, 2006: e16-17).

Such reactions reflect the focus of contemporary health promotion campaigns, which tend to assign a moral duty to new mothers to boost infant health by breastfeeding (Taylor and

Wallace, 2012). The priority accorded to breastfeeding establishes a strong expectation of intense maternal care-giving, disproportionately practiced by middle-class women as a source of esteem (Hays, 1996; Victora et al., 2016; Head, 2017). Indeed, pro-breastfeeding campaigns promise not only significant health outcomes, but also emotional and psychological benefits, often in exaggerated ways (Schulze and Carlisle, 2008). However, many women find that they are unable to breastfeed even to the extent that they had planned (Bartick, 2013: 325).

While early breastfeeding carries esteem, so does bodily modesty (Callaghan and Lazard, 2011; Stearns, 2013) and emotional sensitivity to others (Leeming et al., 2012). Failure to meet these various, potentially conflicting, gendered expectations can cause significant emotional distress for new mothers (Priory Group, 2018). While formula feeding presents no risks to a woman's bodily respectability, it may generate a negative self-evaluation amongst those who feel they have failed to prioritise their infant's health, and so have not measured up to expectations of good mothers (Taylor and Wallace, 2012).

The expectation that good mothers will breastfeed is a feature of the Baby Friendly Initiative (UNICEF UK, 2012). This is a programme for promoting breastfeeding as 'the golden standard of care' in maternity centres and amongst health professionals caring for mothers and infants following birth (Baby-Friendly USA, 2017)<sup>2</sup>. The programme has been widely adopted across the UK, with 100% of births in Northern Ireland and Scotland, 79% in Wales and 58% in England taking place in accredited settings (UNICEF UK, 2017). In the US, the rate is lower, at 22% nationally (Baby-Friendly USA, 2017).

Women have not been imagined as decision-makers in this initiative, but instead as passive recipients of information, training, and support. The success of this programme in improving the rates of sustained, long-term breastfeeding are uncertain. At six months, 49% of US and 34% of UK babies are breastfed, and after 12 months this drops to 28% for US and 0.5% for UK (Victora et al., 2016: Webappendix 17).

Health promotion strategies like this tend to assume that target populations are likely to comply with moral pressure. Such behaviourist expectations take little account of human agency, autonomy, or the indeterminacy of the social world (Emirbayer and Mische, 1998). More socially sensitive approaches to public health, which take account of relationships, interactions and norms, tend nevertheless to prioritise collective over individual goods, harnessing social norms for this purpose. Such utilitarianism treats agents not as ethically valuable in themselves but instead as the means for achieving public health targets. As Buchanan argues, '... the field of health promotion [...] stresses a calculative and instrumental stance toward others' (2000: 44).

The promotion of health by pressurizing individuals to act in prescribed ways is a moralised imposition or interference with autonomy, which insists on conformity at the cost of respecting individuals as moral agents (Coady, 2005). While poststructuralist sociologists tend to take a pessimistic view of moral agency, treating responsibility as an invidious form of power (Rose, 1999: 174-175), critical theory takes the opposite perspective. Moral judgment, or responsibility, is understood instead to be a central feature of agency (McBride, 2013). Responsibility does not necessarily operate as a support for powerful institutions, since the practices of agents are understood as non-determined.

Drawing on critical theory's account of social roles, autonomous agency and the possibility of alienation, what follows considers material drawn from qualitative interviews with women in the early stages of motherhood. The mutual expectations and claims shaping how motherhood was 'taken and made' provide the focus of attention, in a context of concerted breastfeeding promotion. These interviews were carried out for the *Demands of Motherhood* study (Smyth, 2012), a dual-sited project focusing on how norms of selfhood shaped mothering amongst middle-class women in Northern Ireland and Southern California. Informed by the prominence of traditionalist values in both places, including belief in God and respect for authority, nation and the patriarchal family (Inglehart and Baker, 2000), the study aimed to re-examine Hays' argument that middle-class women in Southern California practiced 'intensive mothering', and consider whether this was distinct from other contexts, such as Northern Ireland.

This research was not focused on attitudes to breastfeeding. Instead, it examined the norms embedded in narratives of motherhood. Unlike those in the US, women in Northern Ireland tended to spontaneously discuss breastfeeding in some detail, reflecting the intensity of breastfeeding promotion in this context. All births in Northern Ireland took place in Baby Friendly accredited units by 2016, while at the same time the region has the lowest rates of sustained breastfeeding in the UK, and consequently the world (McAndrew et al., 2012: 35-39). At the time of interviewing, breastfeeding promotion included extensive educational and promotional campaigns aimed at expectant parents and the general public through poster, radio and television adverts, as well as developing accredited material for use in schools. Local businesses and community organisations were targeted for a 'Breastfeeding Welcome Here'

campaign to mark specific public spaces as breastfeeding friendly (Gossrau-Breen et al., 2010; Smyth, 2008). What follows focuses on material drawn from these Northern Ireland interviews, for this reason.

Interview material was subjected to normative analysis, informed by Joas's model of creative action (1996). This focused on normative expectations embedded in respondent narratives of early motherhood, as they sought to appropriate and develop a sense of mastery in the role. What follows focuses in depth on five illustrative cases drawn from the larger sample of twenty interviews. These cases indicate how respondent narratives of coping with the normative and practical demands of early motherhood focused on breastfeeding. Cases have been selected not because they exhaustively illustrate the power of specific factors shaping responses to breastfeeding promotion, such as the degree of social or economic support, but instead because they elucidate some of the personal costs sustained by the pressure to breastfeed.

### **Early Motherhood and the Pressure to Breastfeed**

... that was another big upset, when I couldn't do it [breastfeed], [I thought] I mustn't be a good mum and I can't even feed my own child. (Janet, middle-class, British, married, part-time employment)

The promotion of a moral obligation to breastfeed has generated intense emotional responses to early motherhood, in positive and negative directions. For those who accept that

'breast is best' and can establish and sustain breastfeeding, the reward is a hard-won sense of pride. However, others who accept the message but are unable to breastfeed can experience distress and alienation.

Asked what people think a good mother is, Anita (middle class, British, late 20s, married, full-time at home) responded that 'in this country at the minute, [it's] a mother that breastfeeds', and that from 'listening to the midwives, you kind of have to do it.' Having not had any strong infant-feeding intentions, she tried breastfeeding under the supervision of hospital midwives after her daughter was born, finding it 'genuinely the hardest thing I've ever done'. However, she persisted and gained confidence as she watched her daughter thrive. As she commented:

I [...] definitely, definitely [felt] proud of myself when I did all the breastfeeding. I definitely felt like I'd done a good thing. [It] wasn't easy, but I did it.

For Anita, breastfeeding was not something that she was particularly interested in or committed to in advance:

I had nothing against trying, but I also had nothing against formula feeding. You know my generation were all basically formula fed. I really don't know anybody who was breastfed for that long, you know. We all got a little bit but you know, not much [...]. So, I've no problem formula feeding that way.

The midwives she encountered prompted her to breastfeed, and her baby's positive reaction encouraged her to continue. Anita's sense of pride in herself as a mother, who persisted with breastfeeding despite finding it 'so difficult at times', reflects a sense of having met a high standard of care, albeit not set by herself or reflected in her social context, and which required significant physical and social effort. She devised strategies for breastfeeding in public without exposing her breasts, including feeding with a bottle of expressed milk, or feeding in her car with blankets covering the windows. Breastfeeding was not central to Anita's view of good mothering, so she was able to incorporate it into her role interpretation not as an effect of moralised imposition but instead because her daughter was thriving. As she said, 'had she not been doing so well on it, I would have changed to formula sooner, I know I would have.' Given her non-moralised attitude to breastfeeding, it seems unlikely that an early switch to formula feeding would have resulted in her feeling alienated from motherhood. Nevertheless, her sense of pride, a positive self-evaluation, reflects her perception that she has 'done a good thing', at least in the eyes of healthcare professionals, as she appropriated the role. Pride, a reflexive emotion, indicates our evaluation of how well we meet the expectations we take to be embedded in our social roles (Stryker, 2001).

However, for those who accepted the legitimacy of breastfeeding promotion, but were unable to establish or sustain it, their feeling about themselves as good mothers was very much in question.

Rachel (upper middle class, British, mid 30s, married, part-time professional), a successful professional with a non-gendered approach to parenting, which she shared as much as possible with her spouse, experienced intense pressure to breastfeed from her health visitor,

whose job it was to provide support in the immediate days and weeks following birth. This was very much in contrast to the support she received from midwives in the hospital where she gave birth:

The care I got [in hospital] was amazing. Those midwives are fantastic [...]. Obviously, I wanted to breastfeed, give it a try, and they helped me out a lot in the hospital and, they let me stay on an extra night, 'cause I wasn't, it wasn't all happening. And, that night then, the midwife came in, was helping me out, she said 'I think what needs to happen here is, the baby needs a little bit of formula, cause your milk hasn't come in yet, so, would you mind?' I said 'Not at all'. She said 'this is only topping her up until your milk comes in.' So, that was fine. And then, the midwife, when I came home, the midwife came and she was great and very supportive and [...] very helpful, basically [saying to me] 'don't beat yourself up', you know, 'you're doing well, keep going at what you're doing', all that sort of stuff. Really good.

However, she continued to experienced problems with breastfeeding:

... she was born in December and there was really bad snow. And, it was going into Christmas and New Year, so I breastfed for about two and a half weeks, fully, solely breastfed. But, somewhere along the line, I injured my nipple. You know, it was extremely painful [...] [T]he midwife then stopped coming at that stage, and I seen the health visitor once so, maybe with the advice from my mum and my friends, I stopped breastfeeding and expressed. I expressed three times a day and, gave her formula the



rest of the time. So that was sort of, the, Tuesday before Christmas, and the health visitor came back [...] ten days later. And, there's no other words to describe it, she wasn't happy. And by that stage I hadn't had her on my breast for ten days, and I was happy with the way things were working for us. But [...] by the time she'd gone out the door, I know I maybe should have stood up for myself a bit more, she had her back on my breast. And, then, [partner] was here, thank goodness, and so therefore she like went, I was left in tears. That was really the first time that I really cried, you know I thought that we were getting on well, and I was left to feel that, we weren't.

The distress that Rachel experienced during this and subsequent encounters with her health visitor, who continued to pressure her to breastfeed, did not ultimately leave her feeling alienated from motherhood. She practiced mixed feeding, involving some expressed breastmilk and some formula: 'I just thought, no, I know what I'm doing now, I'm happy, she's getting still the breastmilk in two bottles a day, and, I feel happy with what's happening.' She lost confidence in her health visitor's professional competence following some unconvincing efforts to diagnose the problems she was having with breastfeeding. This allowed her to withstand, to some extent, the health visitor's disapproval: 'I had a few tears, and, luckily [my partner] was here to sort of, snap me out of it'. She was also reassured that her daughter was thriving on her mixed feeding method.

While Rachel accepted that breastmilk was 'the best', she could adapt to her circumstances and feel that she was doing a good job as a mother, meeting her daughter's and her own

needs in the process. She prioritised her relationship with her daughter over her commitment to breastfeeding in her interpretation of motherhood:

Rachel            I wish I still was breastfeeding now, I really do, but I'm not going to beat myself up because it didn't work [...] out for me. I was resenting Lorraine coming anywhere near me, because [...] it was that sore. And it wasn't good for our relationship. So the expressing worked well and I did that until she was eight weeks, and I felt that I'd given her the best, that I could. [...]

Interviewer      And if you do have another baby would you breastfeed again?

Rachel            Definitely, yeah.

This illustration of moral agency involved evaluating and prioritizing the competing demands in play. Rachel's sense of authority as a mother made it possible for her to avoid alienation in the face of moralised interference from the health visitor, although she did experience distress.

Louise (upper middle class, Irish, mid 30s, married, full-time at home), by contrast, faced a more profound struggle with motherhood following the birth of her first child. A successful professional in the private sector who had previously been devoted to her career, she felt overwhelmed by the responsibility of caring for her baby:

the experience of being a mother, at age 30, [...] whenever I had really no other experience before that, was quite a shock, and I think we didn't deal with it very well

[laugh]. I think we were just lost. [...] I think just, you know, you are incredibly selfish when you get to 30 and you haven't, all you've done is, [you] do what you wanted in your 20s. And you get to 30 and you're presented with this thing [baby] and. I always remember thinking, I understand entirely how people can leave their child at a church hall or at somebody's doorway because, I certainly felt that at times. I wanted her to be safe, I didn't ever want to hurt her, but, I just wanted sometimes to get away! [little laugh] And just, not have to have that constant worry.

Her struggle with the role seemed to be encapsulated in her experience of being pressured to breastfeed in the hospital:

They [midwives] were like, 'Oh, but what about your baby, and you should really try it', you know, and that really, stressed me out [...]. [That] probably was a big part in my, struggling initially was this pressure constantly to breastfeed, in the hospital. And when I came home I just stopped it [...]. But I felt like I couldn't stop in the hospital, and that's purely, a sign of, of not [...] realising you could just say no to the midwives, [laugh] you know? And you do want to do your best for your first, [...] you're taking advice and you're assuming these people know, what's best and, you want to do what's best for your baby. And actually it was [my husband who] said to me afterwards, it wasn't what was best for *you*, and, you know, so you don't feel [...] that pressure but that, I think the breastfeeding contributed to me, being even more wrecked, tired, sore, everything. And then, I sort of resented Kirsty [baby], because it was like, 'Oh, if she didn't want this, then I wouldn't have to do it.'

Louise's inability to 'just say no to the midwives', deferring to them as experts and viewing herself as well-meaning but incapable, reflects her struggle to take on motherhood and make it her own. Perceiving health professionals as having authority over the role, and that she needed to adhere to the advice of those who know 'what's best', left her feeling lost when she was unable to meet their expectations. Isolated from family and friends after the birth, she looked to health professionals as primary sources of reassurance for the quality of her mothering:

I felt like I wasn't doing a good job, I didn't feel encouragement from any of the [medical] professionals I met, through the process [...]. [...] I just felt throughout, a sense of that, you know, [laugh] they didn't think I was very good! And it was probably just hormones and, me feeling, you know, feeling out of my depth and, and maybe just assuming that, they thought I was rubbish [laugh]! [...] I didn't really feel a huge bonding thing with Kirsty [baby] initially and, I think you just think then you're not doing a good job and you think, 'oh I should feel differently and I'm obviously doing something wrong'. So I just had this sense of, oh I'm really rubbish at this, and I just want to go back to what I'm good at ...

Louise's sense of her inability to mother left her unable to appropriate the role. The expectations she encountered from health professionals that she would breastfeed on demand, having been 'very routine-driven', compounded her sense of inability to develop a practical relationship to her baby, her self, and her wider social world. She was unable to cope

with the conflict between her pre- and post-maternal self, and so, in Jaeggi's terms, no longer had access to or command over herself and her world (2014: 37). As she recalled,

... as a baby she just scared the life out of me [laugh]. It was just, I didn't feel I could ever make her happy or [...] meet her needs, her expectations. [...] I might have gone, 'Oh I wonder is she hungry? Oh, what'll I do, well maybe she's not, maybe I'll ring someone and ask', and they'll tell me, 'Oh don't be stupid', and, [laugh] you know?

It was only when she began to trust her own judgement, as she put it, that she could begin to appropriate the role, slowly developing a sense of authority as a mother. By the time her daughter was one year old, things had improved: 'you had this walking talking little kid who had a kind of a character, a personality, you could really identify with her'. By the time her twins were born, she had radically transformed her orientation to motherhood, abandoning her high-status career to be at home full time. Again, her interactions with health professionals and the question of breastfeeding captured her sense of the transformation:

So the second time I was just dead set, I wasn't breastfeeding. And, they didn't push it, I think partly cause they're not comfortable with how you breastfeed multiples anyway. So, no one ever even mentioned it to me. But, you know, I kept going out [and asking maternity ward staff], 'Give me more bottles of that stuff [formula]' [laugh]. You know and [...] they were fine about it, they didn't pressure me.

For those who accepted the message that 'breast is best' as a moral imperative, being unable to establish exclusive breastfeeding also had alienating consequences. Ciara (lower middle

class, Irish, early 20s, lone parent, part-time shift worker) was herself a health-care professional. Unlike Louise, she was fully committed to breastfeeding prior to her son's birth:

I was in hospital for about four or five days afterwards, and they [staff] were fantastic.

[...] I wanted to breastfeed, and couldn't. It was just, he didn't latch on properly, but I kept insisting and insisting. I wanted to give this a go, and he was crying.

[...]

He was on my breast for 23 hours. He was trying and trying [to feed]. And he just wasn't getting enough. So then, we did start bottle feeding. [...] I kept going and kept going for about three weeks, but every time I was putting him on I was in agony. So I kept thinking, I'm not doing this right, I'm a terrible mother. Mum had my aunts and cousins come around to talk to me and they were just, 'no, this isn't a bad thing'. But I felt so guilty. And it was the midwife that came out afterwards and the health visitor, both sorta went, 'Look, just stop it. You're not enjoying it, he's not enjoying it, he's obviously not, some babies just don't get enough. And, you know, he's obviously not, would you come off it?' I felt I needed counselling more, for coming off breastfeeding than trying to go on it, cause it was something that I really wanted to do. But then he was, straight away drinking six, seven ounces of milk, from the formula, and, och, he's just a huge hungry, hungry baby.

Ciara's struggle to practice breastfeeding as the moral standard of maternal care had a damaging effect on her self-conception as she took up this new role, under difficult circumstances where her pregnancy was the surprise result of a chance encounter on holiday.

Finding herself a lone parent, dependent on her own parents and family for support, and unable to breastfeed, she experienced post-natal depression: 'at the start, [...] I felt so low and [...] I just found it hard to get out of the house'. She felt that she was not doing a good job as a mother:

I didn't think at times that I was doing the best thing for him. There was times, whenever if, like with standing at the front door, you couldn't, just couldn't leave [breaks down].

She managed to cope with the help of anti-depressant medication. However, she recalled the early days with her baby son:

I think I just sort of wanted to cocoon myself with him, and just have everybody, like, go away, either preempt what I need and do it for me directly or just don't bother even coming at all because, you know, I just can't handle it

A young woman in her early 20s, she tried to overcome her sense of alienation by focusing on meeting her baby's immediate needs: 'I just sort of felt like, well this isn't about you, this is about him. Pull yourself together and get on with it.' She slowly stopped seeking approval from her own mother and began developing a sense of her authority in the role: 'the early part of it I think, I really just did things to try and please my mummy, rather than to try and please me. And I know that sounds a bit strange, but I really did.' As a lone mother from a

Catholic community, her own mother, who had been 'shocked, and [...] a bit upset' about the pregnancy, was her primary source of support during early motherhood. Ciara's mother provided detailed instructions for her on how to care for her baby, which she tended to follow even when she didn't agree:

'... it was, very much, "mummy thinks I should be doing this" so I'd be doing that, you know. [...] I didn't sort of feel that I could really stand up for myself [...] [because I was a] silly girl [who] went and got herself in trouble in the first place...'

Ciara didn't comment specifically on whether her mother supported her efforts to breastfeed, but she did encourage her to stop when it didn't seem to be going well. By the time her son was two years old, she had overcome her depression and felt that she was 'doing an alright job'.

I think I'm coping well and [my son is] happy, he's healthy, he's, you know, he's got everything he needs, not necessarily everything he wants but everything he needs. And he's a very loving, very affectionate wee boy.

Although she feels that her life has in many ways been compromised by motherhood, 'I have sacrificed my body, I have sacrificed my friendships, my romantic life, my career', the evidence of her son's health and happiness despite not being breastfed provided sufficient reassurance that she was doing a good job, and she was able to feel proud of herself as a mother:



... on occasion [...] people that you don't maybe know as well, that are coming up and going, 'You're doing a brilliant a job!' And it's like, 'Thanks very much!', [...] I'm probably going to go home and cry for the rest of the night, but hearing it from other people makes *such* a difference

[...]

[to feel that] you're not the world's worst mother.

The narratives discussed here demonstrate the strength of public health as an authoritative force shaping the mother role in Northern Ireland. They also indicate the possibility of alienation, when this authority is accepted and the ability of actors to take and make motherhood is limited. The ability to interpret roles in a way that realizes the actor's intentions as well as her sense of what a good mother should do, meeting the needs of infants, significant others and one's self in the process, is crucial if alienation is to be avoided. This can hinge on narratives of success or failure with breastfeeding in contexts such as this, where it is intensively promoted.

## **Discussion and Conclusion**

Breastfeeding is an intensely social as well as biological experience, shaped by conflicting normative expectations and institutional demands (Hausman, 2003). When pressure is brought to bear on women to breastfeed in the first hours, days and weeks after giving birth, the role becomes rigidly defined. This undermines agency, the ability to 'take and make' motherhood, developing some command over the role through interpretation and improvisation.

The experiences of women in Northern Ireland, where formula feeding has prevailed during the twentieth century, and breastfeeding has been intensively promoted in recent years, illustrate the consequences for new mothers. Some women, such as Anita and Rachel, who take their interpretation of the role from non-health service sources, including their own mothers and male spouses, can treat breastfeeding as valuable only to the extent that it works for themselves and their babies. However, others, such as Louise and Ciara, who rely primarily on health professionals for guidance in the initial stages of motherhood, are much more vulnerable to alienation when they are unable to meet the expectations they encounter. Post-natal depression can be understood as a form of alienation in circumstances such as these, when a key institution seeks to impose a moral duty to care in a specific way as a mark of 'the best' form of early mothering.

The cultivation of practical reasoning, what Aristotle defined as *praxis*, requires 'insight into the singularly salient features of the particular situation at hand' (Buchanan, 2000: 87). Unlike scientific reasoning, which relies on fixed procedures to arrive at the right decision, practical reasoning depends on the situated judgment of the agent. An approach to health promotion which expects new mothers to exercise such judgement about infant care, rather than subjecting them to an externally imposed moral code, would reduce the risk of alienation (e.g. see Fed is Best, 2018).

The UK's Royal College of Midwives has recently stated that all infant feeding decisions made 'after being given appropriate information, advice and support on breastfeeding' should be respected (The Royal College of Midwives, 2018). This suggests an important step towards demoralization. Breastfeeding promotion strategies such as the Baby Friendly Hospital

Initiative have recently come under pressure, following a systematic review which found no consistent evidence that such system-level interventions improve breastfeeding rates (Patnode et al., 2016: 1699; Strauss, 2018). These recent developments suggest a policy shift towards supporting women to exercise practical judgement rather than pressurizing them follow general rules.

Promoting breastfeeding in a way that emphasizes that maternal autonomy should guide infant caregiving, would reduce the pressure on women to breastfeed at all costs (Buchanan, 2000). This might involve facilitating a range of infant feeding options in post-natal settings; establishing an unequivocal right to breastfeed in public places; and making it easier to combine breastfeeding with employment (Flaherman and Kohorn, 2016). Comprehensive supports for autonomous role interpretation could be developed which enable agents to interpret motherhood with some authority, exercising situated moral judgement. When the practices of motherhood are overlaid with moral imperatives, the ability to develop a practical command over one's roles, and consequently one's self, can be compromised.

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## Notes

1. For example, the central character in the film *Precious* becomes a mother in her teenage years because of sexual abuse by her father. She also experiences domination from her mother. As she begins to develop an autonomous life, she makes motherhood her own and successfully secures the return of her older daughter to her care. See Daniels L. (2009) *Precious*. Icon Home Entertainment.
2. Birth centres and hospitals seeking accreditation must follow ten steps to promote breastfeeding. See World Health Organisation, and UNICEF. 2018. "Ten steps to successful breastfeeding (revised 2018)." Geneva: WHO

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